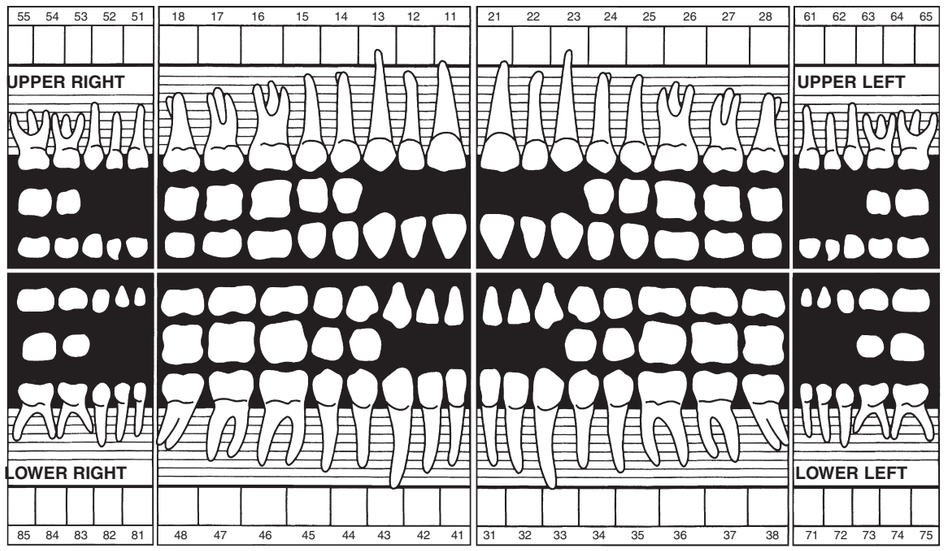
MEDICAL HISTORY

1. Are you being treated by a medical doctor for any medical condition? ..... Yes ☐ No ☐
2. Are you taking any drugs or medications? ..... Yes ☐ No ☐
3. Are you allergic to, or have you reacted to, any drug or medicine? ..... Yes ☐ No ☐
   i.e. local anaesthetic (freezing), Penicillin or other antibiotics, sedatives, analgesics, pain killers?
4. Have you ever had surgery or radiation treatment to the face or jaws? ..... Yes ☐ No ☐
5. Do you have, or have you had, any of the following diseases or problems:
   - (a) Rheumatic fever or rheumatic heart disease? ..... Yes ☐ No ☐
   - (b) Hip or Joint replacement? ..... Yes ☐ No ☐
   - (c) Congenital heart lesion or heart murmur? ..... Yes ☐ No ☐
   - (d) Cardiovascular disease: e.g. Heart trouble, Heart attack, Stroke, High blood pressure, Arteriosclerosis, Angina? ..... Yes ☐ No ☐
   - (e) Chest pains or shortness of breath? ..... Yes ☐ No ☐
   - (f) Asthma, hay fever, skin rash, other allergies? ..... Yes ☐ No ☐
   - (g) Diabetes? ..... Yes ☐ No ☐
   - (h) Kidney disease? ..... Yes ☐ No ☐
   - (i) Hormone disorder: e.g. Thyroid? ..... Yes ☐ No ☐
   - (j) Hepatitis, jaundice or Liver disease? ..... Yes ☐ No ☐
   - (k) Lung or breathing disorders: e.g. Tuberculosis, Emphysema? ..... Yes ☐ No ☐
   - (l) Gastrointestinal disease or Ulcers? ..... Yes ☐ No ☐
   - (m) Nervous disorders or Mental illness? ..... Yes ☐ No ☐
   - (n) Bone, Muscle or Joint disorder? ..... Yes ☐ No ☐
   - (o) Cancer? ..... Yes ☐ No ☐
   - (p) Venereal disease, Hepatitis or AIDS? ..... Yes ☐ No ☐
6. Do you bruise easily or bleed excessively from cuts? ..... Yes ☐ No ☐
7. Women only:
   - (a) Are you pregnant or nursing? ..... Yes ☐ No ☐
   - (b) Are you taking oral contraceptives or hormone therapy? ..... Yes ☐ No ☐
   - (c) Have you reached menopause? ..... Yes ☐ No ☐
8. Do you have any other disease or condition not listed above? ..... Yes ☐ No ☐

   If so, please specify _____

DENTAL HISTORY - NEW PATIENT ONLY

9. Have you been under regular dental care? ..... Yes ☐ No ☐
10. When did you last have dental X-rays? .....
11. Have you ever had a problem associated with any previous dental experience? ..... Yes ☐ No ☐
12. Are you unhappy with the appearance of your teeth? ..... Yes ☐ No ☐



PERIODONTAL SCREENING & RECORDING

SEXTANT SCORE DATE _____
SEXTANT SCORE DATE _____
SEXTANT SCORE DATE _____
SEXTANT SCORE DATE _____
SEXTANT SCORE DATE _____
SEXTANT SCORE DATE _____
SEXTANT SCORE DATE _____
SEXTANT SCORE DATE _____

CLINICAL NOTES

PRODUCTION DETAILS/DÉTAILS-PRODUCTION
BACKPRINT
Format: Head to Head
BK BLACK 100% NOIR